VIVA HEALTH

VIVA PREFERRED

Effective Dates: Coverage Beginning On or After January 1, 2020
Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
PRIMARY CARE SERVICES:	
• **Preventive Care & Other Office Visits** ○ Routine Physicals ○ Covered Immunizations ○ Hearing Exams ○ Medical Physician Services ○ X-Rays ○ Illness and Injury	$25 Copayment per visit
SPECIALTY CARE: (No PCP Referral Required)	
• **Medical Physician Services**	$45 Copayment per visit
• **X-Rays**	100% Coverage
• **OB/GYN Services** (One OB/GYN Preventive Visit every Calendar Year)	$45 Copayment per visit
URGENT CARE CENTER SERVICES:	
• **Medical Physician Services** • **Illness and Injury**	$45 Copayment per visit
TELADOC TELEHEALTH SERVICES:	$45 Copayment per consultation
VISION CARE: (No PCP Referral Required)	
• **One routine vision exam per Calendar Year**	$45 Copayment per visit
• **Other eye care office visits**	$45 Copayment per visit
ALLERGY SERVICES: (No PCP Referral Required)	
• **Physician Services**	$45 Copayment per visit
• **Testing**	80% Coverage
LABORATORY PROCEDURES:	$5 Copayment per test
• **Covered Genetic Testing**	80% Coverage
DIAGNOSTIC SERVICES: (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	$225 Copayment per service
HOSPITAL SERVICES:	
• **Inpatient Services**	$600 Copayment per admission
• **Outpatient Services**	$225 Copayment per service
MATERNITY SERVICES: (Covered for employee and employee's spouse; not covered for dependent children)	
• **Physician Services** (Prenatal, delivery and postnatal care)	$45 Copayment per delivery
• **Maternity Hospitalization**	$600 Copayment per admission
Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.	
EMERGENCY ROOM SERVICES:	$150 Copayment per visit *(Copayment waived if admitted to hospital)*
EMERGENCY AMBULANCE SERVICES:	80% Coverage
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: (100 Days per Lifetime)	80% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	$0 Copayment
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic supplies call VIVA HEALTH.	100% Coverage
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to 60 Total Inpatient Days and 25 Total Outpatient Visits per Calendar Year)	80% Coverage
HOME HEALTH CARE SERVICES: (Limited to 60 Visits per Calendar Year)	80% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required; covered up to 25 Visits per Calendar Year)	$45 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$45 Copayment per visit
SLEEP DISORDERS:	$45 Copayment per visit
• **Sleep Study**	$225 Copayment per sleep study
TRANSPLANT SERVICES:	$600 Hospital Copayment
MENTAL HEALTH SERVICES[1]:	
• **Inpatient Services**	$600 Copayment per admission
• **Outpatient Services**	$45 Copayment per visit

[1]Treatment at a residential facility is not a covered service. Substance abuse services are excluded from coverage. Certain diagnoses are excluded from mental health coverage. See the Certificate of Coverage for details

VIVA HEALTH

VIVA PREFERRED

Effective Dates: Coverage Beginning On or After January 1, 2020
Attachment A to Certificate of Coverage

PHARMACUETICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[2]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$5 Copayment per 31-day supply
○ Mail-order	$12 Copayment per 90-day supply
○ Participating Pharmacy	$15 Copayment per 90-day supply
• **Tier 2 (Generic Drugs)**	
○ From a Participating Pharmacy	$20 Copayment per 31-day supply
○ Mail-order	$43 Copayment per 90-day supply
○ Participating Pharmacy	$60 Copayment per 90-day supply
• **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$40 Copayment per 31-day supply
○ Mail-order	$86 Copayment per 90-day supply
○ Participating Pharmacy	$120 Copayment per 90-day supply
• **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$65 Copayment per 31-day supply
○ Mail-order	$162 Copayment per 90-day supply
○ Participating Pharmacy	$195 Copayment per 90-day supply
• **Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	90% Coverage
• **Diabetic Testing Supplies** (OneTouch glucose meters, OneTouch glucose test strips, and any brand of lancets/lancet devices)	100% Coverage

[2]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [3]May be administered in the home, physician's office or on an outpatient basis. There is a Member out-of-pocket maximum of $10,000 per Member per Calendar Year for biological, biotechnical drugs and specialty pharmaceuticals. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to www.vivaemployer.com/Members/Default.aspx

When Generic is available, Member pays difference between Generic and brand price, plus Copayment.
Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

VIVA HEALTH CUSTOMER SERVICE (205) 558-7474 or (800) 294-7780
VISIT OUR WEBSITE at www.vivahealth.com

Eligible Dependent: Eligible Employee's lawful spouse and children of Eligible Employees under age 26 or disabled dependents who meet eligibility criteria. Dependents with a last name different from employee's must be verified as eligible through submission of a marriage or birth certificate with the enrollment application.

Pre-Existing Condition Policy: No pre-existing condition exclusions or waiting period.

Nondiscrimination Notice: VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language Assistance Services: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務．請致電 1-800-294-7780 (TTY :711).

VIVA HEALTH believes this health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on the dollar value of essential health benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to VIVA HEALTH Customer Service at (205) 558-7474 or 1-800-294-7780. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov. For plans subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.